The ageing crisis is now, says Task Force

DEIDRA CLAYTON

The crisis of the ageing population is now and cannot be postponed if those more than 65 years of age are to maintain an adequate quality of life. During the next 20 years there will be need to dramatically remodel the health care system and to devote more resources to this segment of the population. That was the thrust of a report of the Canadian Medical Association-funded Task Force on the Allocation of Health Care Resources.

Task Force chairman Mrs. Joan Watson said if the rate at which old people are placed in institutions goes unchecked, "the costs will not only be prohibitive, we will perpetuate the callous practice of warehousing the elderly."

Mrs. Watson is well known as long-time host of CBC's prime time television program, "Marketplace". Last year she resigned to become chairman of the five-member task force. It was charged with assessing the allotment of health dollars and manpower in light of an ageing population and increasing dependency on medical technology.

Other members of the task force included: The Honourable Pauline McGibbon, former Lieutenant Governor of Ontario; Roy Romanow, former deputy premier and Attorney General of Saskatchewan; Dr. Leon Richard, chancellor of the University of Moncton and medical director of the Hôpital Docteur Georges-L. Dumont, Moncton; and Dr. John O'Brien-Bell, a family practitioner in Surrey, BC.

The task force's attractive, 148-page coffee-table book is much more than a final report. First, it represents the CMA's footing the $500 000 bill, which allowed a "mainstreeting" or counterbalancing force last year while federal-provincial politicians busied themselves with bringing the Canada Health Act to its climax. To the task force's persistent credit, the luminating report represents a refreshing antedote from that apogee.

Second, with its numerous graphs and tabulations from two major research studies commissioned by the members, the report is a jumping off point for all partners — the health care community at large, government and the general public — to reopen discussions on important major health issues.

Finally, this timely commentary is also evidence of the task force's avocation to push for a permanent Canada health council. The proposed council would be financed both publicly and privately. Composed of consumers, ombudsmen and health professionals, it would advise politicians and perform various tasks. For example, it would design policy research on matters of de-institutionalizing, rationalizing and regionalizing health care services. And it would generate information as well as publish its findings.

Among the council's many hats, it would resolve jurisdictional disputes between provider groups and oversee the performance of another of the task force's brainwaves — a permanent health ministers' secretariat.

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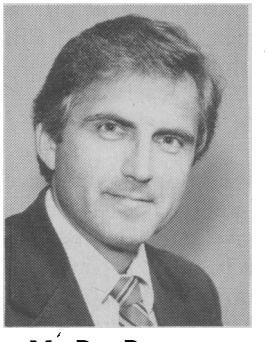
The Task Force on the Allocation of Health Care Resources

The Honourable Pauline McGibbon

Dr. John O'Brien-Bell

Dr. Leon Richard



Mr. Roy Romanow

Mrs. Joan Watson

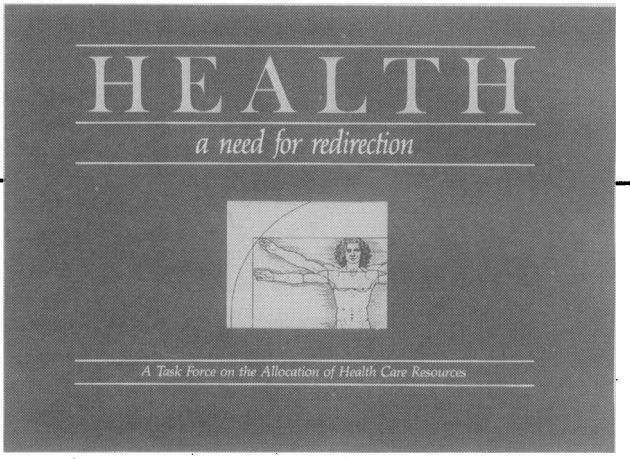
The council would be purely an advisory organ: a forum where members could "knock heads and dream a little. It would act as a lobbiest, a reconciler, a visionary and an animater." In essence, it would become the conscience of the whole system.

Fundamentally, the report itself has served to move public consciousness into the "reality" arena. Says Dr. O'Brien-Bell: Who knows better than a general practitioner that on average, our patients are getting older? Yet an absence of "bridge" programs to help physicians, families and individuals cope with moving the elderly from episodic care back into the community, plus an increasing shortage of vacancies in nursing homes, mar treatment. As a result, these inadequacies have stamped the stigma of "burden" on the elderly.

Because the type and supply of nursing homes and institutions vary across the country, "it's tough to get your message across", said Mrs. McGibbon. "In most cases, once seniors enter a nursing home they feel as though they have been tossed down a chute. Nursing homes I've seen appear to be run on tender, loving greed. What use are standards without inspection?"

Dr. O'Brien-Bell referred to results of a study showing that if we stay on our present course, "an unprecidented construction activity to provide one thousand, 300-bed, long-term care facilities, would be needed to accommodate the elderly."

The 150-page report prepared by the Toronto-based, management consultant firm of Woods Gordon, looked at the demographic changes facing Canada over the next 40 years, and the impact that poses on our health care system. The report advised there would be a need for an additional 118,000 hospital beds and 276,000 long-term care beds by 2021. The report suggests: ". . . by the year 2021, demographic changes alone will increase current expenditures on health care by about 75 per cent to over $32 billion — if current patterns of providing care remain unchanged. This converts to an annual increase in current expendi-



A Summary of the report of the Task Force on the Allocation of Health Care Resources

The summaries of the six chapters that follow are reprinted directly from the report.

• Consumers' "Wish List"

A number of consumer concerns are collected together in this chapter. They range from a perceived lack of interest by health care practitioners and a call for more responsiveness to the needs of an individual, to improved ambulance services, the provision of transportation for the sick in remote areas, and concerns over the present cumbersome portability provisions. The elderly represent an area of major public concern. Of particular interest are the recommendations for more consumer registries of health care information, more ombudsmen, a Patients' Bill of Rights, and a Canadian health council.

• The Elderly

Canada's elderly population has received too little attention in the past, and the health services available to them are inadequate. A major problem identified is that if we continue to put old people in institutions at the rate we do now, the costs will not only be prohibitive, we will perpetuate the callous practice of "warehousing" the elderly. Old people do not want to live in institutions.

The evidence presented to the Task Force was overwhelmingly in favour of a new program of care for the elderly, which emphasizes independent and productive living at home. If the appropriate community support systems could be put in place, this is not only possible, but also cheaper.

Population projections are presented in this chapter which demonstrate that indeed, the present policies and rates of institutionalization cannot continue. Not only would significant increases in operating budgets be required, but the necessary construction activity would be prohibitive. The projections also show that there will be a greater increase in the numbers of elderly in the next 20 years than in the first 20 years of the next century. This issue is therefore with us now, and cannot be postponed. The planning period for provincial governments is also, therefore, relatively short.

Some solutions are discussed in detail: promoting the well-being of the elderly to encourage their activity and independence; providing various community services; and the wider adoption of palliative care programs. The effect of such policies is discussed by means of specific scenarios. It is shown that the magnitude of the increased demand for resources

tures of about 1.4%."

By reducing the number of elderly in institutions and implementing various scenarios, the report indicated that the 1.4% average annual growth could be reduced to 0.8% of GNP.

Three "financial savings" schemes suggested are:

- reduce the number of elderly in institutions;
- decrease the number of mentally ill patients in facilities;
- cut back on the overall length of stay in hospitals for all patients.

The de-institutionalizing solution is not just a cost-saving device, the report concluded: "Developing community services to keep the elderly out of institutions for as long as possible, not only reduces costs, but enhances the quality of life."

At the same time, introducing a compassionate, coordinated program for the terminally ill, would also reduce demand for new beds. The main thrust of palliative care would be towards encouraging death with dignity in the home.

Certainly a period of adjustment would be needed to beef up services suggested by the task force report. Some of these include: home health care, meals on wheels, respite care, a renewed emphasis on transportation, health maintenance of teeth, vision, hearing and foot care; day surgery, mobile health units, plus an continuing education program.

On a gloomy note, the study cautioned that the usual lead time is no longer on the side of planners. There is no 20-year grace period; the so-called ageing crisis is already upon us.

Placing pins in the seats of government via the proposed council would hope to spike action from various bureaucracies that prevent "the coordination of the various institutions, compounded by their division between the health and social services jurisdictions", the report said.

A newly-developed coordinated care system would emcompass multi-level care facilities, would enable individuals to move freely from one level of care to another; and would assess services to see that the needs of each individual can be periodically evaluated and met.

Indeed, a veritable shopping basket full of consumer requests poured forth from some 260 briefs submitted at open hearings in 14 cities across Canada. So a chapter appropriately labelled, "Consumers wish list" itemized expectations that ran

could be substantially reduced by the adoption of new policies.

Two further problems are also discussed. First, there is a lack of coordinated services (multi-level care facilities) covering the complete spectrum of needs for the elderly. These are essential if the right kind of care is to be available to each individual. A successful model in Toronto is discussed.

Second, the standard of care provided in many nursing homes is grossly inadequate. They provide a life of immobility and tedium, and lack any guarantee of adequate basic care. In the short run, the problem requires the implementation of strict regulations enforcing meaningful standards. The problem also points to a more permanent solution. It is recommended that all jurisdictions move as quickly as possible towards the elimination of "care for profit" institutions and establish non-profit facilities.

• Medical Technology

The use of high technology is now an integral part of medicine. The dramatic increase in the use of medical technologies in recent years has not only substantially improved medical care but also brought a host of new problems. Perhaps the most obvious is cost. It is likely that costs will continue to increase. Although some modern technologies can indeed achieve remarkable results, it would appear that there are others which may in fact be useless or even harmful. There is a concern over the seeming inadequacy of evaluation procedures. The inordinate faith that consumers appear to have in modern medicine may therefore be misplaced. The limitations on resource availability call for economic evaluation and yet society does not seem ready to reduce the value of life to a matter of dollars and cents. A related moral question is whether technologies can be withheld on the grounds of cost.

New technologies have fundamentally altered the nature of hospital and medical care. Specialization has increased the remoteness of the physician, and an emphasis on "caring" has been reduced. The rise in litigation and the consequent move by doctors to a greater emphasis on "defensive medicine" have created new problems. Finally, there is the problem of how to ensure accessibility to technology for people in rural and remote areas.

Three particular recommendations are made as a means for controlling technology costs while increasing the availability of effective procedures. First, a uniform set of guidelines for evaluating, acquiring, operating and funding high technology must be established. To this end, the Task Force suggests the establishment of a National Health Technology Assessment Council.

Second, there is a need to rationalize and coordinate the provision of technologies. The Task Force particularly endorses the principle of regionalization, the sharing of facilities, both intra- and inter-provincially, to provide improved health care services and greater accessibility. The provision of adequate transportation services is also important.

Third, since it appears that the "everyday" technologies are contributing disproportionally to the overall costs, we urge that means to control their use should be investigated, such as by placing responsibilities on the practising physician, and monitoring clinical practices. Such reforms might imply significant changes in clinical practice, and therefore repre-

the gamut: starting with "women want midwives" and moving across the spectrum to a physician's request for a universal medical credit-card.

Another string of arguments endorsing the principle of "regionalizing" health services percolated from the brief. These are:

- to improve integration of services, thus avoiding costly duplication;
- to improve coordination of services provided by many different suppliers, such as police, ambulance and emergency services in order to provide better access;
- to give communities a better handle on organizing the "mix" of services in a specific region.

Generally, the report endorsed a move away from total dependency on government to resting more decision-making powers on the shoulders of the end users, particularly concerning medical technology.

A McMaster University study conducted by eight academics was commissioned to study our increasing reliance on medical technology and its cost-effectiveness. In the chapter called "Medical Technology", the task force made three major recommendations.

- A National Health Technology Assessment Council to provide the essential coordinating, monitoring and assessment functions when new technologies are introduced.

The McMaster team stressed that assessment should not concentrate on specific technologies only. "Policies designed to create an attitude or state of mind towards the introduction of technology may be more effective than legislative policies." As a footnote, the team contended that "changing behaviour may be more effective than controlling it".

- Another solution was again in line with rationalization. The study said sharing facilities such as "telemedicine", diagnostic trucks, and specially trained nurses to visit the home should be allocated on regional criteria instead of basing distribution randomly or for political reasons.
- Since reports indicate "everyday" technologies jack up costs "at least as significantly as high technological procedures, doctors should combine clinical freedom with more management responsibility and work within clearly-defined budgets, for which they would become responsible".

Dr. Leon Richard added yet another twist: "Medical schools have to look at problems of training new

sent a major challenge to the medical profession.

Finally, new medical technologies should not be feared. Our aim should be to introduce them in an orderly, rational and cost-effective manner.

• Consensus and Cooperation

The health care system in Canada today is complex and fragmented. It is characterized by conflict and confrontations between the federal and provincial governments, and providers of health care which prevents meaningful discussion and hinders the implementation of changes in direction and policy that are so badly needed. The pattern of the evolution of health care and financing arrangements in Canada has been one of "tug and pull" between the federal government and the provinces about standards of health care, and who pays for them.

Compounding these serious problems is a pressure on resources, exacerbated by the explosion of new technology and the growing numbers of elderly people. Further, the health problems we now face are complex and expensive to treat: the degenerative diseases such as heart disease and cancer, and the ill health caused by the lifestyle society continues to inflict upon itself. It seems likely that tomorrow's health problems will be at least as complex as today's and will continue to impose further demands on our resources.

The Task Force proposes three solutions to these problems. First, the role of the Federal-Provincial Council of Health Ministers should be strengthened and expanded.

The second recommendation is to establish a Canadian health council to provide a forum for consumers, providers and governments to work together to identify the key problems related to health, to visualize new horizons, to resolve jurisdictional disputes between providers, and to serve as an overall guardian of the integrity of the health care system. Research would be an important component of the council.

Third, a significant restructuring of the health care system is proposed that would incorporate the principles of dividing a province into a series of areas so that the health needs of these "local regions" can be planned and provided as one unified service. This concept would imply a shift from an almost exclusive reliance upon governments to an active participatory role by communities.

• Funding

Resolution of the "adequacy of funding" debate is hindered by the conflict that exists between federal and provincial governments. There is a dichotomy between those who are responsible for health care budgets and those who make the decisions that spend them. There is little information to guide us in reaching conclusions about the adequacy of funding: we do not know the extent of inefficiencies in the system and to establish that the Canadian health care system is underfunded requires convincing evidence that spending more money will indeed provide a measurable improvement in health, and that this improvement is greater than that which could be achieved by spending the money in some other way. There is a basic conflict between consumers, health

students at high technological centres, who become lost when they have to work outside these tertiary care centres." He said that a growing impression that hospital specialists are highly paid engineers dependent on complex technology presents medical schools with a challenge to maintain the supply of well-rounded doctors, "who are in the best sense of the word, generalists."

In the chapter entitled "Funding", the report concluded that the task force couldn't assess the extent of existing inefficiencies and because there is no guarantee that putting more money into the system is necessarily the best way of improving health . . . the question of funding must be addressed immediately, "preferably by a body such as an independent health council."

For the short run, two specific recommendations are given:

- a special tax credit to charitable organizations that devote monies for research on cancer, heart disease, diabetes, arthritis, and rehabilitation and treatment of the disabled and elderly; and
- whenever possible, the costs of particular health services should be publicized to providers and consumers. The media should be encouraged to quote costs.

Another recommendation in this section calls for a method of measuring health output, otherwise consumers, health care providers and government will continue to bicker over the concept of "scarcity" or "rationing".

Grappling with the "underfunding" question also left the members somewhat at a loss, notably because of the cost-efficiency vs. quality-of-life riddle. The task force admits its position regarding "underfunding" is equivocal: "because the evidence is contradictory and inconclusive, the Task Force does not support the contention that there is underfunding generally in Canada. However, the regional disparities in the range of health care services available, point to the need for additional assistance to be given to the poorer provinces."

Unfortunately, it is difficult not to fly the inequities creating the "have not" groups into the face of more costly biomedical engineering solutions. But they also contribute to quality of life. And to be sure, the industry has been hamstrung from stepping back to look at the larger picture. But as the report says: "It is a matter of spending money on health care to save it elsewhere." ■

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care professionals and governments over the concept of "scarcity" which insists that all societies must ration resources. All these problems are compounded by common misunderstandings with respect to health care expenditures which are not borne out by the data.

The various arguments made to us in support of "underfunding" or "adequacy of funding" have been summarized in this chapter. Because the evidence is contradictory and inconclusive, the Task Force does not support the contention that there is underfunding generally in Canada. However, the regional disparities in the range of health care services available point to the need for additional assistance to be given to the poorer provinces. If cost containment policies are allowed to continue to restrain capital expenditure in the current fashion, the quality of medical services will be significantly diminished.

Finally, in the light of the demographic study which shows the forthcoming wave of aging Canadians, a policy of deinstitutionalizing the elderly must be devised if health care spending is to remain a manageable proportion of gross national product.

• Wellness

There is a gratifying indication that society is ready to switch from a concept of health care based on sickness to a pursuit of wellness. But problems arise in its implementation. Despite the awareness of the importance of wellness and how to achieve it, people continue to engage in lifestyles which cause ill health. The positive effects of preventive medicine have also been given widespread publicity, yet preventive measures could be practised more widely. There is a lack of political will to impose restrictions and legislation. As we eliminate some unhealthy habits, others appear in their place.

One of the keys to promotion of wellness is education designed to prevent illness. Legislation provides another way of achieving lifestyle changes. Another way to influence behaviour is to "hit people's pockets", for instance, through taxes.

Fee schedules could be amended to encourage doctors to spend more time on counselling and consultation. Community Health Centres have the incentive to keep their patients well, and provide wellness and preventive programs. All health care professionals can play a major role in promoting wellness. A concerted research effort in the fields of wellness and prevention is needed, particularly to seek ways to bring about lifestyle changes: making people aware of how they should modify their behaviour is not necessarily sufficient. Survey data to identify those groups most at risk is needed.

Alcohol, smoking, accidents, suicide and drugs take away more years of life than all other causes put together. "Self-destructive" behaviour is the major killer in our society. The areas of greatest promise for improvement in the health status of Canadians lie in the promotion of wellness, lifestyle, nutrition and preventive medicine.

But the promotion of better health will not necessarily reduce health expenditures. It might simply allow us to live long enough to develop the infirmities of old age. This is why it is essential to act now to improve the manner in which we care for the elderly. ■